I. Introduction and Purpose

In the fall of 1995, DHSS Deputy Secretary Lorang assigned the Bureaus of Community Mental Health, Substance Abuse Services, and Health Care Financing, to form a work group to explore managed care for persons with mental illness and substance abuse. The Division of Care and Treatment Facilities was later added to the group and assisted in the review of this paper before it was presented to the Deputy Secretary. The specific assignment to the work group was to identify a process to develop model(s) for managed care service delivery and funding to be piloted and evaluated in the 97-99 budget period or sooner for persons with mental health/substance abuse treatment needs with the intent of statewide implementation by 2001. The paper is also intended to articulate the shared values, principles, and goals the three Bureaus want to present to the stakeholders to review, edit, and eventually guide the project to develop managed care. This paper is the product of the work group (see membership in the Appendix 3). The paper was shared with 38 individuals representing mental health, HMOs, consumers, families, counties, etc. (see Appendix 1). Their feedback and comments have been incorporated into this document.

This paper was not intended to address the myriad of details and implementation issues that will accompany a project of this scope, nor would it have been appropriate for the Department to do so in the absence of the stakeholders that we have identified. Rather, this paper discusses the vision, broad guidelines, and objectives that DHSS desires to achieve with this initiative.

II. Problems This Paper Addresses

There are three problem areas that this paper attempts to remedy. These are described below:

1. While counties have, in many ways, managed care through the 51 system, their efforts have been hampered by categorical funding limitations which have often resulted in fragmented care, poor access to some effective services, and skewed fiscal incentives. Furthermore, the current systems of mental health and substance abuse services are separated from the physical/medical health care system, much to the detriment of the consumers.

2. It is important that the Division of Community Services (DCS) and Division of Health (DOH) share a common vision and are in agreement regarding strategies to improve services. This paper articulates a joint vision for the new Department of Health and Family Services (DHFS) that is based on a collaborative approach and agreed upon strategies among various divisions and bureaus.

3. Counties, families, providers, and consumers have not felt adequately involved in the design of service programs and funding streams that greatly impact them. This paper outlines the process that will be used to seek out that input and involvement.

III. Vision

The work group developed a vision statement to guide the process and product for the proposed pilot models for service delivery and funding for persons with mental health and substance abuse treatment needs. This vision is stated below:

> All persons in need of mental health and substance abuse services funded by federal, state, or local taxes, regardless of age or degree of disability, have access to appropriate high quality services that promote health and wellness, improvement and recovery, quality of life, and self sufficiency.

IV. Operating Assumptions

In this section are the assumptions that form the "operating framework" for the future service delivery system implementation. The three bureaus within the two Divisions are in strong agreement with these assumptions.

1. The participation of clients/customers and their families is critical in the design and successful implementation of the managed care system.

2. Managed care will serve as the tool to shift the current substance abuse and mental health delivery system toward the vision articulated above that emphasizes prevention, early intervention, improvement, and recovery.

3. Little/no new funding will be available. Any service improvements/expansion will be achieved by re-directing resources from inpatient and other restrictive services to community-based services that promote recovery, improvement, early intervention, and relapse prevention.

4. Statewide, orderly implementation of managed care for persons with mental illness and substance abuse will require four-six years, including a piloting phase with a comprehensive evaluation followed by statewide implementation.

5. All sources of public funding including federal, state, and county tax funds now supporting these services need to be integrated into a single health care delivery system. Incentives need to be developed that encourage the integration of other non-public funds that promote development of integrated, wraparound services. The system will be developed to allow for the maximum flexibility in the use of these funds.

6. When implemented statewide, there are likely to be several different organizational arrangements that coordinate county and HMO provided services.

7. The system of care must integrate physical health services and mental health and substance abuse treatment with rehabilitative, social, and support services into a seamless, wraparound health care delivery system.

8. The designed system will be capitated and transfer the risk from the state and possibly the counties to qualified vendors.

9. The managed care models piloted will be based on research and evaluation findings derived from national and in-state programs.

10. The results of the pilots and statewide implementation will be disseminated nationally to assist other states to implement state-of-the-art managed care models.

11. Counties need to be significantly involved in the design and implementation of the system due to their current financial and human resource investments.

12. The designed system will need to address the special issues associated with individuals involuntarily committed to treatment or otherwise involved with the criminal justice, juvenile justice, and child protective service systems.

13. The state maintains overall responsibility for the care and treatment of persons with mental health/substance abuse disorders and will, along with key stakeholders, be responsible for the ongoing evaluation of the quality and outcomes of the programs.

V. Definition of Target Population

The target populations who will receive services are described below. The process to determine the target population will be based on feedback from the stakeholders described in Section VIII. It is possible that the population will be defined more narrowly through this process. Three options for target populations are:

Option 1: Medicaid eligible individuals who are not enrolled in the W-2 health plan; or

Option 2: The population described in Option 1, plus individuals on SSDI who are also Medicare eligible; or

Option 3: The populations in Options 1 and 2, plus other individuals seeking care from the public sector mental health/substance abuse treatment system, e.g., the uninsured, persons on the Relief to Needy Indians Program (RNIP), persons on general relief, and persons who want to purchase services from this plan.

There are a number of specific populations in addition to the three broad groups that need to be considered for inclusion. Groups such as:

- < Expensive, long-term users of services
- < Women with children who are not part of W-2
- < Persons treated at the following institutions (not limited by payer source): State mental health institutes, institutes for mental disease (IMDs); child caring institutions (CCIs), nursing homes; and/or county jails (county-custodial jail inmates needing MH and/or SA services).

VI. Desired Goals and Objectives of Model(s)

This section will define the characteristics of pilot model(s) that Wisconsin wishes to include. Pilots will be deemed desirable if they meet these goals and objectives.

1. Enrollees and family members are central in the system. They are represented at all levels of system decision making, and are involved in all aspects of care plan development and implementation.

2. Managed care is a tool for providing health care that meets the person=s needs in a holistic way and based on preventive services and wellness outcomes.

3. Comprehensive managed care contracts for Medicaid transfer the risk from the state, and possibly the counties, to qualified vendors, who must meet defined contractual standards and conform to contract requirements.

4. All sources of reimbursement are integrated into a single program of care. At a minimum, risk-adjusted capitation rates should cover all Medicaid covered services.

5. Risk-adjusted capitation is used to support providers who serve the most complex enrollees and to reduce incentives for seeking favorable risk selection.

6. Managed care delivery systems must result in three measurable outcomes: higher quality care, better client outcomes, and the opportunity for savings to the State and counties.

7. Quality of care is measured for selected indicators through utilization data, chart reviews and chart data, adequate access to necessary and appropriate services, and client/family satisfaction.

8. Client outcomes are measured for improvement in functioning, reduction of symptoms, and improved recovery based on client and collateral ratings.

9. Provider networks are composed of providers with experience and expertise serving the enrollee population, including culturally sensitive providers.

10. There is a single entity that oversees the development of a coordinated system of care for persons with mental illness and substance abuse.

11. Comprehensive, individualized assessment and service planning is provided to every enrollee.

12. A single point of responsibility is assigned for care coordination that integrates physical health services, mental health treatment, substance abuse treatment, and treatment with rehabilitative, social, and support services, and long term care as appropriate.

13. Each individual's care is provided by a clinical team that includes a primary care/specialty partnership with full participation and involvement of clients and families.

14. Clinical decision-making and service provision occur in a variety of settings, including the doctor=s office, emergency room, hospital, home, work site, and school.

15. Early intervention strategies are used to prevent relapses and prevent long term conditions.

16. Systems exist to make urgent care response by a knowledgeable clinician accessible to enrollees 24 hours/day, 7 days/week.

17. The latest clinically defensible research and evaluation and customer/family and provider satisfaction studies are incorporated into programs on an ongoing basis to achieve consistent program improvement process.

18. The pilots will be tested only in areas where significant key stakeholders are supportive of the pilot and willing to participate in the implementation.

19. There will be a well defined grievance and advocacy system modeled on that used in our current managed care programs.

VII. Description of Options

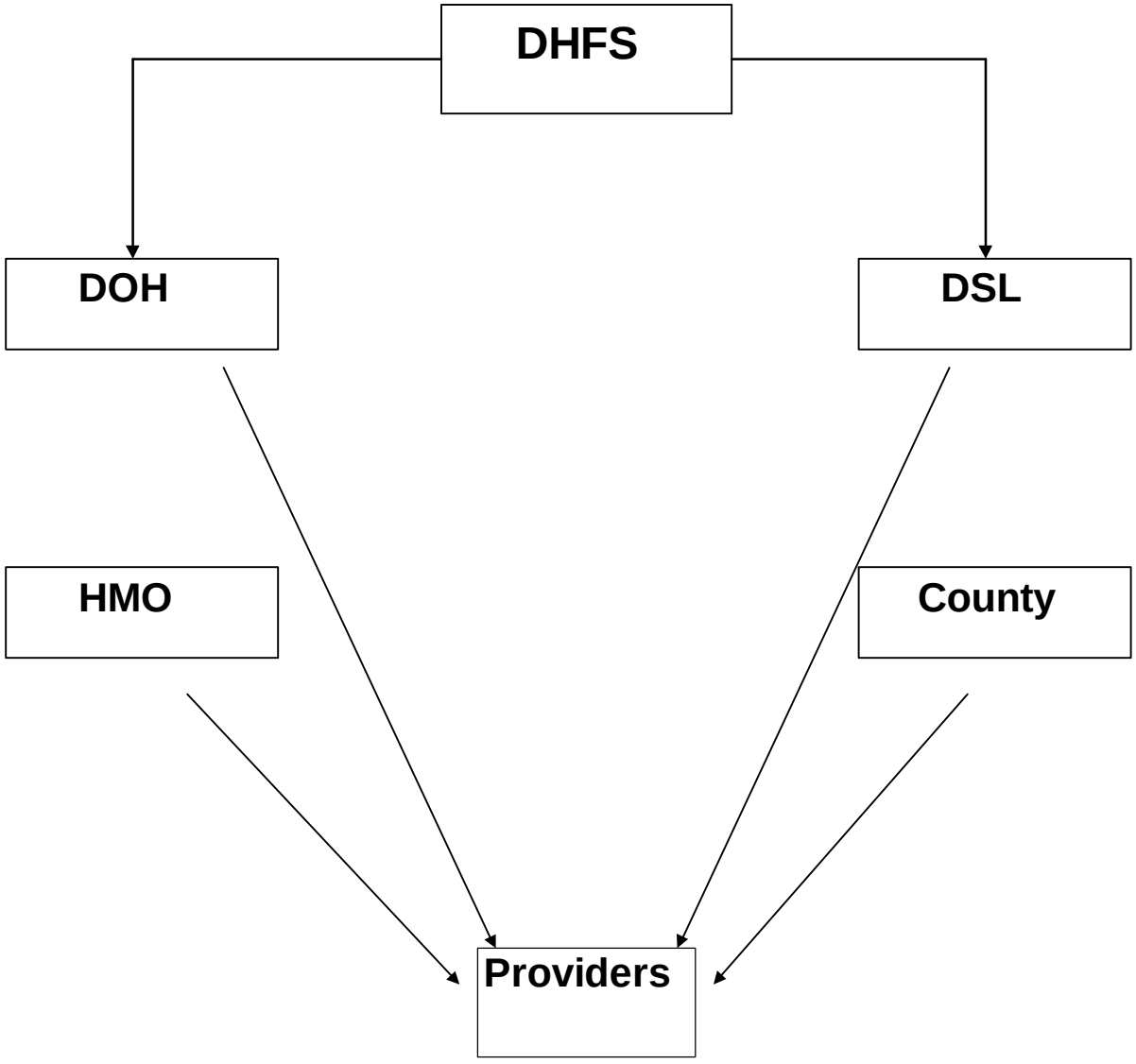
These are the five proposed models of managed care programs for persons with substance abuse/mental health service needs that could be piloted in Wisconsin. Based on the vision and goals, pilots should be comprehensive and provide for all the health care needs of the pilots= enrollees, including substance abuse and mental health services, as well as the needed rehabilitative and other support services. Pilots should be capitated with full risk (or almost full risk in the pilot phase) occurring to the HMO entity. The growth costs should be predictable and the pilots should be evaluated based on quality of care and measurable client outcomes.

These options describe the contractual arrangements for provision of services. The options are described as follows:

Table 1. Current model

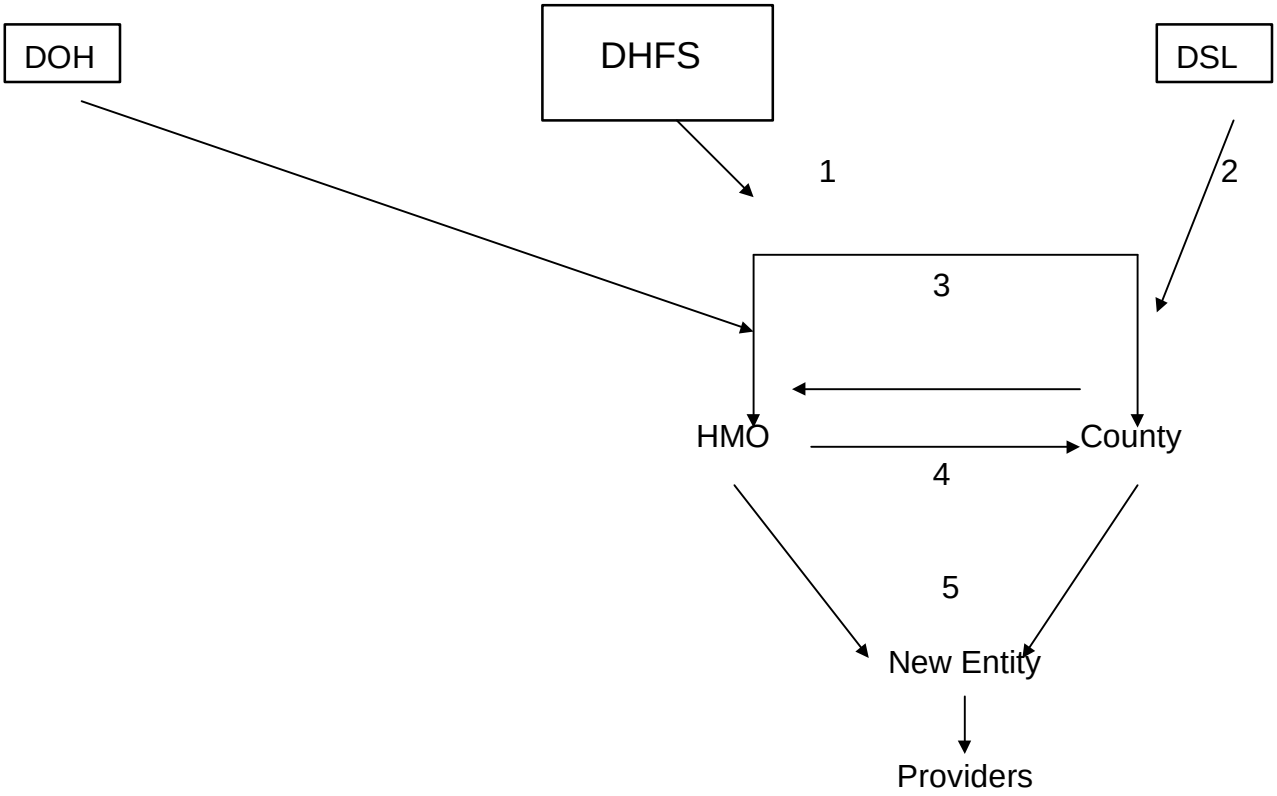
Table 2. Overview of the proposed options and the commonalties in each option
Tables 3-7. Individual options

Table 1: Current Model



Current Model: Currently DHFS is a payer for services through both DOH and DSL. DOH pays individual service providers directly through the Medicaid fee-for-service system and also contracts with HMOs. The HMOs then contract with providers to provide services. DSL provides money to the counties through community aids which the counties then match with tax levy and use to provide services directly or purchase services from other providers. DSL also contracts directly with providers for certain services.

Table 2: Overview of Future Options

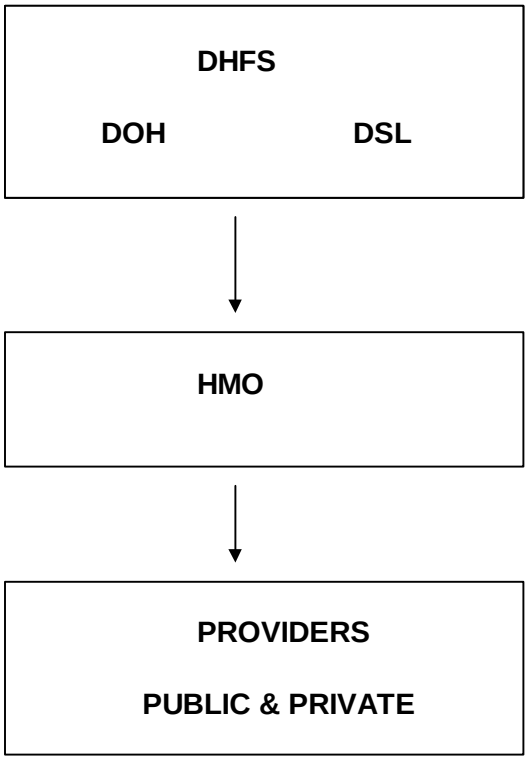


Common themes in all five options on pages 8-10:

- pooled funds
- capitated system
- risk based
- managed
- comprehensive, i.e., holistic

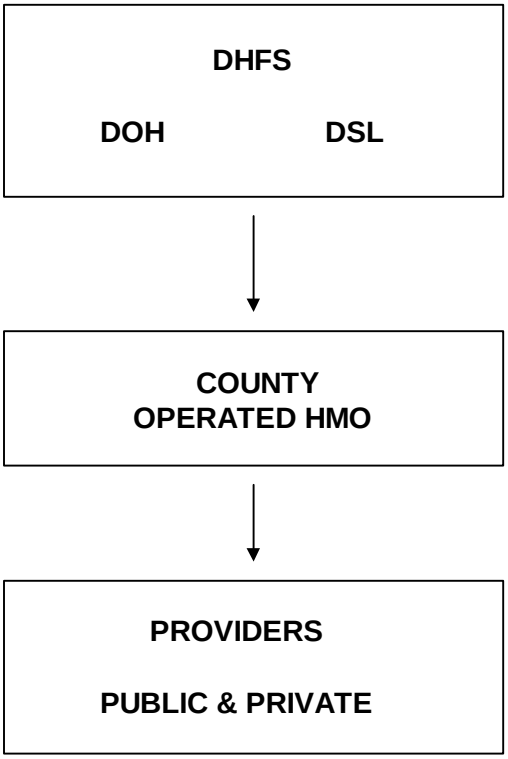
Overview: The overview identifies the main players: DHFS, HMOs, counties, and providers. The options differ, mainly, as to at which level the blending of funds occurs. In options 1 and 2, blending occurs at the DHFS level with all funds going to either an HMO or a county. In options 3 and 4, the blending occurs at the "middle" level: counties and HMOs either form a legal partnership or counties contract with HMOs to provide services but retain their current funding streams. Option 5 creates a new entity "below" the counties and HMOs which is funded by all three players. In all cases' providers are funded by a single entity which is responsible for care management and can authorize services as needed.

TABLE 3: OPTION 1



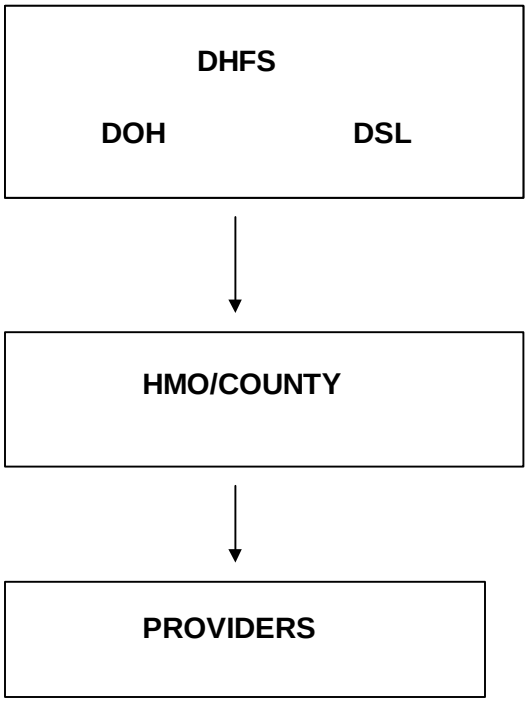
Option 1: DHFS contracts directly with HMOs. The HMOs contract with providers, be they public (counties) or private.

TABLE 4: OPTION 2



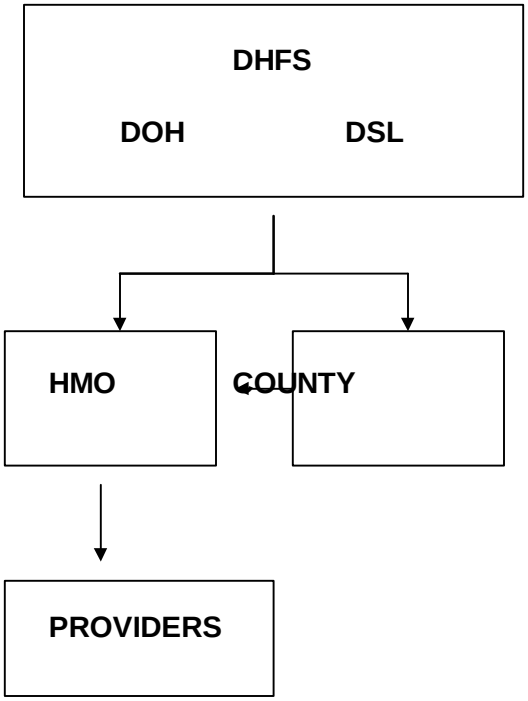
Option 2: DHFS contracts with a county, which is itself the HMO or managed care provider. The county then contracts with providers.

TABLE 5: OPTION 3



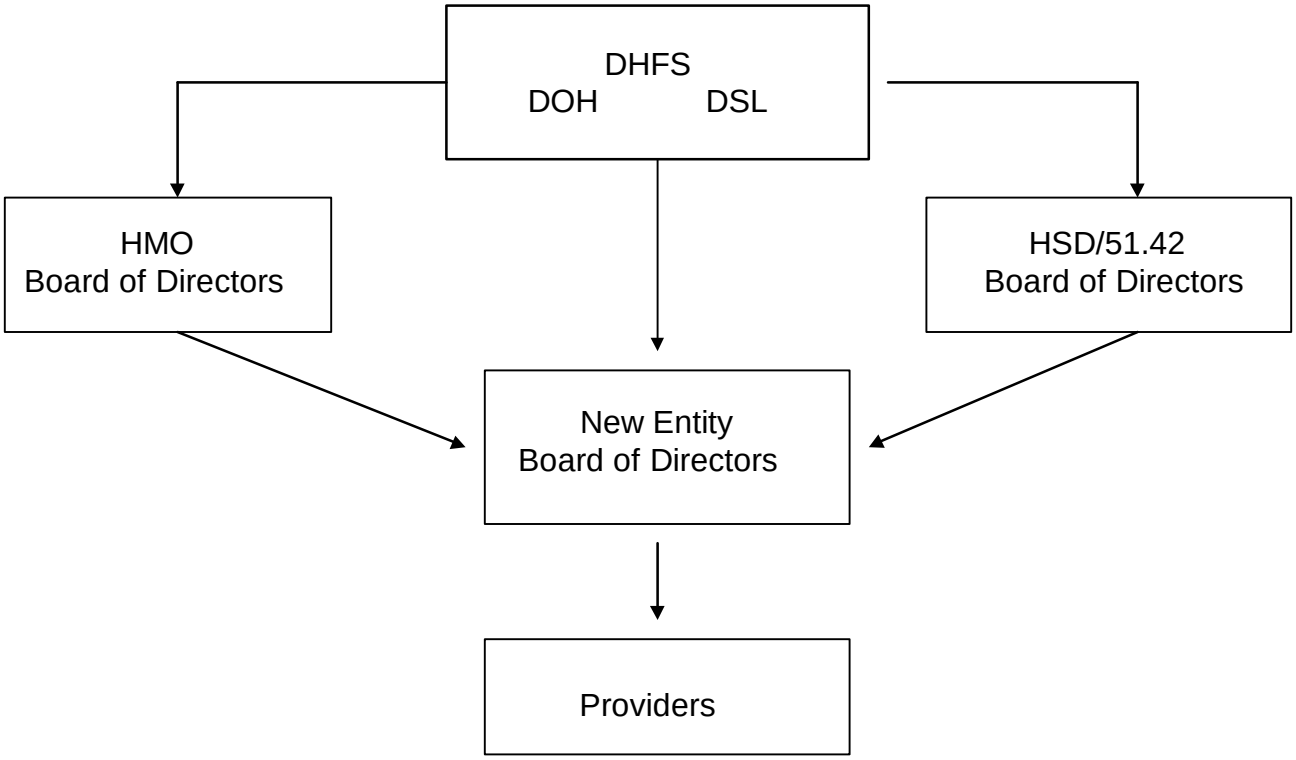
Option 3: DHFS contracts with an entity which is a partnership between an HMO and a county. This entity then contracts with providers.

TABLE 6: OPTION 4



Option 4: DHFS contracts with both HMOs and with counties, similar to the current model. The county, in turn, contracts with an HMO, rather than directly with providers. The HMO contracts with providers to serve both the Medicaid and "county" clients.

Table 7: Option 5



Option 5: A new entity is created to manage services. DHFS, counties, and HMOs all contract with this entity, which in turn contracts with providers.

VIII. Process to Include Other Interested Parties/Stakeholders

The other parties will include but not be limited to county representatives, payers, managed care entities, consumers, family members, service providers, and legislators. The involvement of these groups has three phases:

Phase 1: Share paper with selected reviewers (Appendix 1) for comments.

Phase 2: Share paper with stakeholder groups (Appendix 2) for comments.

Phase 3: Involve stakeholder representatives in design and implementation workgroups.

IX. Timetable

The following is a possible timetable for completing recommendations for inclusion in the 1997-1999 budget process:

1. The Secretary approves the process paper by January 15.

2. The process paper is shared with specific stakeholders and revised based on their comments by April 30.

3. Disseminate the paper widely for input by May 15.

4. A workgroup of Department staff and stakeholder representatives meets to refine the working paper: June 30 - August 1.

5. Internal Departmental review and inclusion into the budget recommendations by August 15.

6. Establish an ongoing implementation workgroup to develop the RFP, evaluation design, etc., by July 1996.

7. Hire needed staff by December, 1997.

8. Implement pilots by July 1998. (Need one year to implement after legislative authorization.)

9. Evaluate pilots by July, 2000.

10. Propose statewide expansion starting at end of 1999-2001 budget, assuming favorable initial evaluations.

Revised 5-16-96

Appendix 1: Names of persons who reviewed and commented on the managed care paper before sent out to broader stakeholder groups:

< Francine Feinberg, Meta House

< Carey Tradewell, Women=s Center

< Mike Florek, Tellurian, Madison

< Kathleen Crowley and Randy Stratt, Patient Action Network

< Mike Hert, Intervention and Treatment Committee

< Ron Frederick, Kenosha Community Programs

< Peter DeSantis, NorthCentral Community Programs

< Barry Blackwell, Wisconsin Psychiatric Association

< Doug Johnson, Washington County HSD

< Kathie Eilers, Milwaukee County HSD

< Mike DeMares, Waukesha County HSD

< Larry Schomer, Mental Health Council

< Dianne Greenley, Wisconsin Coalition for Advocacy

< Roger Young, EDS, AODA Consultant

< Pat Jerominski, Humana

< Marilyn Drianoni, Medicaid Working Group

< Bruce Kamradt, CATC, Milwaukee County HSD

< Lynn Green, Dane County HSD

< Tom Johnston, Sinai Samaritan

< Catherine Beilman, AMI of Dane County

< Tom Saari, Winnebago County HSD

< Joanne Griesbach, Mental Health Council

< Gregory Schmidt, UW Madison Medical School, Milwaukee

Appendix 2: Stakeholder Groups

- Wisconsin Counties Association
- Wisconsin Counties Human Service Association
- Alliance for the Mentallly Ill of Wisconsin
- Mental Health Association of Milwaukee
- Wisconsin Consumer/Survivor Workgroup
- Wisconsin Family Ties
- Wisconsin Coalition for Advocacy
- Wisconsin Psychiatric Association
- Wisconsin Psychological Association
- Wisconsin Social Work Association
- Mental Health Council
- Mental Health Blue Ribbon Commission
- Wisconsin Alcohol/Drug Treatment Provider Association
- Wisconsin Association of Alcohol and Other Drug Abuse
- State AODA Council, specifically the Intervention and Treatment Committee
- HMO Association
- Wisconsin Hospital Association
- State Medical Society
- MH/AODA/Aging Statewide Task Force
- Department of Public Instruction
- Department of Corrections

Appendix 3: Staff involved in drafting this paper

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Appendix 4: Glossary

Culturally sensitive providers: providers who understand and respect the culture and lifestyle of minority populations and are able to provide care that takes these differences into account.

Early intervention: the delivery of appropriate services when symptoms first manifest themselves in order to prevent worsening of symptoms and the need for more expensive services at a later date.

HMO: a particular type of managed care entity which can provide a full range of medical services and must be licensed by the State to ensure it has adequate financial reserves to enter into risk contracts.

Managed Care: various strategies that seek to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performance to ensure cost-effectiveness.

Prevention: services that might prevent onset of a particular disorder. For example, stress management classes, nutrition education or parenting education.

Recovery: a process of changing one's values, feelings, goals, skills, and/or roles. A way of living a satisfying, hopeful, and contributing life even with the limitations caused by the illness or disability.

Risk adjustment: the process of setting different capitation rates for different sub-groups of enrollees based on the projected costs to serve them. Risk adjustment helps guard against the managed care provider serving only recipients with less complex needs.

Risk Sharing: the requirement that the managed care provider accept a fixed dollar amount per enrollee to provide any or all needed services. Risk to the provider may be limited in a number of ways such as by having a stop-loss arrangement or limiting potential loss or profit to some pre-set amount (e.g., 5% of contract value).

Support services: services not traditionally considered to be treatment but which allow individuals to function at their highest possible level within the community; e.g.; mentors to work with emotionally disturbed children and their families.

Wraparound: a philosophy of care which stresses that services provided be based on the specific needs of the individual and family as opposed to fitting them into predetermined service slots